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Embodied expertise: women's perceptions of the contraception consultation

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ABSTRACT This research, based on qualitative interviews and non-participant observation, emerges from a larger study investigating what factors influence the 'contraceptive careers' of British women in their 30s. The women informants recognized that contraceptive products often impacted on their health, but viewed them as distinct from 'medical matters'. Rather than doctors being seen as having expertise, it was women health professionals, be they nurses, midwives, health visitors or doctors, who were perceived as the ones who 'know' about contraception, through an assumption that they are contraception users. This embodied knowledge is valued by the women above their formal medical training. I will also show how general practice surgeries and family planning clinics were viewed as gendered spaces, which altered the expectations and experiences of the women during contraceptive consultations. This study found that as 'real' expertise over contraception stems from embodied rather than textual knowledge, the women's choices were grounded by a gendered sense of trust.

KEYWORDS *contraception; embodied knowledge; medical consultations*

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Introduction

Contraception has a long and embittered history that illustrates women's desire and struggle to achieve control over their reproduction, particularly in relation to laws, regulations and instruction by the Church, State and medical profession. During the 20th century, the medical profession acquired control of access to most forms of contraception in Britain, which

increased the possibility for both surveillance and control over women's sexual lives, particularly after the development in the late 1960s of the contraceptive pill. Consequently, in order to understand mid-life British women's diverse and multifaceted experiences of contraception it is necessary to consider the role of medicine in the provision of contraception.

This article will begin by briefly outlining the development of medical surveillance over contraception, and consider how this and the health implications associated with many methods of contraception shape women's experiences. I will then describe the methods used in this research. Using the descriptions provided by the women, I will argue that despite its apparent 'medicalization', women consider contraception as distinct from 'medical matters', and that 'real' expertise over contraception stems from embodied rather than textual knowledge. The women advocated a model of autonomous health consumers. However, their choice of health-care providers was grounded in a gendered sense of trust.

The medicalization of contraception

The medicalization of contraception is one area that has received considerable attention from feminist researchers. As Oakley (1993) has pointed out, one of the essential differences between the historical use of contraception and today's use is the widespread involvement and control by the medical profession that has led to considerable surveillance over women's lives. Contraception has an anomalous position within medicine. It is prescribed, often for extended periods in large numbers to 'healthy' women, and thus women users are not 'patients' in a conventional sense. Yet the medical profession still controls access to many forms of contraception,¹ and most forms, especially ones that are based on hormones, have short- or long-term health implications for the women who are using them.

Medical surveillance and the 'responsible' woman

The medicalization of contraception has led to considerable surveillance over women's lives. Moreover, within the doctor/patient exchange, the medical profession has long been considered in a position of power (Turner, 1995). Although, as Doyal (1994) highlights, the National Health Service (NHS) guarantees women access to health care, women's subordinate structural position (both within the NHS and as service users) disadvantages them and has serious implications for their ability to access information and treatment. Yet, the doctor/patient relationship is more complex than a simple hierarchical power relationship. Foucault (1990) has argued that patients are complicit in the production of power/knowledge through the clinical encounter, and it has also been suggested that patients are increasingly adopting a consumerist approach that challenges the doctor's authority (Haug and Lavin, 1983). However, while it is important not to underestimate the complexities of the power relationship, ultimately, as

many methods of contraception are only available on prescription, it is necessary to consider how medical discourses inform doctor's perceptions, and are thus implicated in the doctor/patient power relationship.

Feminist researchers have highlighted how many doctors do not consider that women can be trusted to make the 'right' or 'rational' decisions over contraception, and this perception informs and recasts the power relationship between women users and health providers (Foster, 1995; Hawkes, 1995). Although explicit eugenic agendas are rarely referred to in Britain today, there is evidence that in relation to contraception, women are judged on social rather than medical grounds. These attitudes are closely linked to attitudes towards the biological and social role of mothering, which also produce normative notions and moral judgements about which women should avoid pregnancy, and when (see, for example, Thomas, 1985; Hawkes, 1995; Smart, 1996). Moreover, as Martin (1987), among others, has illustrated, women's bodies are often considered as irregular, temperamental and in need of regulation and this discourse affects the way that all aspects of reproduction are perceived. Indeed, Howson (1998) has suggested that normative femininity requires acceptance of the medical gaze, and an 'embodied obligation' in compliance, although this does not imply that women comply without questioning.

Not only are women evaluated in relation to their ability to be a 'good' mother, but they are also judged on the likelihood of them complying with the medical regimes of contraception prescribed to them. Hawkes (1995) argues that health professionals divide women by their own perceptions of 'responsibility' and 'irresponsibility', and certain categories of patient, such as young women, almost always fall into the 'irresponsible' group. Thus women who are perceived as 'irresponsible' are more likely to have methods of contraception recommended to them that require little or no patient intervention, such as injections or an Intrauterine Device (IUD also known as a Coil) (Todd, 1984; Foster, 1995).

Although socially produced, the purpose of contraception is ostensibly biological, and it certainly has disciplinary effects on the body. In addition, there is a paradox in which perceptions of women's bodies as disordered and irregular and in need of control, meet a 'rational' need to control fertility, and these competing images in/form both the design and prescription of contraception. Watkins (1998) points out that early advertisements for doctors stressed how the contraceptive pill regularized women into a 28-day cycle, and the contraceptive pill is still recommended for women who have erratic periods (Rees, 1995).² Moreover, medical control of contraception is often justified explicitly on clinical grounds, but the evidence suggests that moral judgements about both individual women and the threat to social order are often intrinsic to their decisions (see, for example, Hawkes, 1995; Barrett and Harper, 2000). Furthermore, the medical profession has sometimes perceived these concerns as more important than the iatrogenic effects of contraception (Foster, 1995).

Contraceptive risks to health

The methods of contraception currently available not only vary considerably in their effectiveness, but many of them also have detrimental effects on women's health. Alongside the discomfort that many women endure in order to try to control their fertility, there are also serious and even life-threatening conditions that are associated with contraception.³ There is also considerable evidence that doctors routinely dismiss or disregard the reports of adverse side effects from women, and also fail in many cases to inform women fully of the long-term health risks and known side effects (see, for example, Pollack, 1984; Doyal, 1995; Foster, 1995; Walsh, 1997). Moreover, even prolonged use of a particular method cannot be taken as a positive endorsement, as many women feel that they have no realistic alternative to the method they are using, and so have to accept any unpleasant consequences associated with that method (Snow et al., 1997).

Many reasons have been suggested to explain the lack of attention paid by the medical profession to the health problems associated with contraception. For example, Todd's (1984) research on contraception consultations found that male doctors often dominated conversation with women patients about contraception and negated women's capacity to express their concerns. In addition, the power invested in medicine and a medical discourse which constructs women as irrational and unreliable, gives credence to the idea that problems women encounter are imagined or unconnected to the method of contraception (Foster, 1995). Moreover, even when side effects are admitted, it is assumed that these are a minor inconvenience when compared to the benefits of control over fertility (Luker, 1975; Foster, 1995).

Consumption, trust and medical encounters

Models of consumerism in health care often stress choice, access to information and shared decision making (Henderson and Peterson, 2002). In Britain, since the late 1960s, women have been able to choose between different NHS service providers for contraception and ostensibly choose between methods. While access remains controlled, contraception, unlike most other medicines, is supplied free through the NHS. So perhaps contraceptive consultations could be seen as an exemplar in a consumer model of health care?

However, as Irvine (2002) points out, while ideas of health consumers potentially reconfigure professional/patient relations, often they have not led to any radical shifts. Rather, they have often reinforced notions of 'responsible' patienthood in line with traditional ideologies and practices. While women have a formal entitlement to choose a method of contraception, they do so within a complex web of differing health implications, and may need information or clarification from health professionals. This requires a degree of trust in the health professional's expertise.

As Lupton (1996, 1997) has pointed out, despite a substantial increase in

criticism of the medical profession, most people retain a level of trust in their doctors. She argues that once ill, the patient is also emotionally dependent on their doctor, as they need to be cared for, and the concept of the rational 'health consumer' does not fully account for this. As Mechanic and Meyer (2000) have shown, trust in medicine has varied dimensions including feelings about competence, responsibility, control, disclosure and confidentiality. The relative importance of each dimension to a particular patient will vary and is often related to the patient's individual circumstances. Both Möllering (2001) and Lee-Treweek (2002) suggest that trust is established through investment by the patient in the process. Möllering (2001) argues that while trust can involve elements of rational decision making, it also involves a leap of faith between an individual's interpretation of the issues and the expectation of a preferred outcome. Möllering describes this mental process as suspension, when an individual accepts the unknowable of the interpretation, as the crucial element in trust. In this model, those that report a general decline of trust in experts would argue that this 'leap of trust' is no longer premised in an automatic respect of their knowledge base.

Lee-Treweek (2002) also argues it is the phenomenological processes of patients that establishes the trust. Her study of an alternative health setting allows us to see the establishment of trust between patient and provider of health care outside of the historical status of established medical knowledge. She argues that recommendations from an individual's social network and a belief in the credibility of the therapy need to be confirmed through the actions of the practitioner in establishing trustworthiness. Consequently, rather than the trust being related to the practitioner or therapy per se, the encounter or therapy needs to be grounded in a sense of familiarity with patients' pre-existing ideas for trust to be achieved. Trust is then contingent on both an assessment of professional expertise and behaviour, and the extent to which this relates with the patient's worldview. However, the extent to which these types of model are relevant to contraceptive consultations as women users are not 'patients' has yet to be established.

Methods

This research was designed to identify and investigate the complex power relationships in which women's choices and decisions over contraception are enmeshed. All the women recruited were in their 30s, and this age band was chosen as there has been a tendency to concentrate contraceptive research on younger women, especially around the issue of teenage pregnancy. Many women in their 30s change sexual partners; they may marry or remarry, separate or divorce. Some women in this age group may want to have children, others do not. Despite the lack of attention given to them, contraception remains an important issue for mid-life women. Interviewing mid-life women also allowed me to take a life-course approach, within which women could reflect back over their lives, and discuss what pressures

led them to make particular decisions at which points in their lives. I felt that by concentrating on women in their 30s, I could not only explore an under-researched group, but would also be able to gain a better understanding of how women's needs and choices changed over the course of their reproductive lives. Prior to the start of the fieldwork, permission was granted by a medical ethics committee.

In-depth interviews have long been believed to allow people to define the issues that they see as the most relevant, compared to a more formal questionnaire that would limit research to pre-chosen topics (see, for example, Ribbens, 1989; Burgess, 1993). To try to reach women using a variety of contraceptive methods, two different routes of access were chosen: a general practice (GP) surgery and a family planning clinic. These two research sites were chosen as they represent the two most common avenues for women to obtain prescriptions or supplies of contraception in Britain, and I also wanted to explore the preferences of the women for one site or another. Moreover, while the women using the clinic services were mainly current users of prescription contraception, recruitment through the surgery elicited accounts from women not currently using a prescription method. Within the interviews, a detailed contraceptive history for each woman was also taken and thus other routes of access to contraception, such as post-natal consultations within maternity hospitals were also discussed. In total, 22 interviews took place, mainly in the women's own home, and they lasted between one and two hours.

At the GP surgery, a letter was sent to a random sample of 130 female patients aged between 30 and 39. This generated 13 initial responses of which 11 women were interviewed. The surgery was on the edge of a small city within the West Midlands conurbation and was chosen as it had a range of different housing types within its borders, and covered both an urban area and some villages, which indicated that their patients were likely to fall within a range of social classes.

The other women were recruited when they attended for appointments at an urban family planning clinic and I also carried out non-participant observation of contraceptive consultations at the clinic over a six-week period. At the clinic the women were given information about the study at reception, with the nurse or doctor carrying out recruitment. There were 57 women in their 30s who had appointments during this period, of which 21 consented to be observed and 11 were subsequently interviewed.

In any research in which people volunteer their time, the sample is likely to consist of predisposed respondents who are happy to discuss the topic, and while it is not possible to assess accurately whether non-respondents' experiences are similar, the women's accounts did not seem to be extraordinary. I had hoped that by adopting the methods outlined above I would be able to interview a range of women with varying personal circumstances including different class, ethnic and religious backgrounds. However, despite care being taken to ensure that there was diversity in the women

approached, the women who agreed to be interviewed proved to be quite a homogenous group.

In total, 18 of the 22 women interviewed stated that they were white English or British, two white Irish, one woman was Taiwanese and one was Turkish. By self-definition, five women were middle-class, thirteen were working-class and four stated that they came from a working-class background but their occupation or income meant that they could be considered as middle-class now. Five women were Catholic, three stated that they were Church of England, there was a Buddhist, a Taoist, a Muslim and a Baptist, while the other 10 stated that they had no religion. Twenty of the women had children, although all of them had been pregnant at some point in their lives. All the women were in the target age range of 30–39.

At the time of interview, 13 of the women were married, and one was cohabiting. Two of the women described themselves as in long-term relationships (but not cohabiting) and two stated that they had just started new relationships. Two women were currently separated from their husbands, although one of these was working towards reconciliation, one woman was a widow and one described herself as single. Since this snapshot picture does not reflect the complexity of the women's lives, as it does not take into account the range of past relationships that they had been in, during the analysis the women's contraceptive experiences were compared on the basis of their circumstances at the time of each method choice, rather than status at the time of interview.

The interviews used open questions to explore the women's accounts, and as far as possible followed the women's lead in the topic under discussion. They did aim to cover specific areas including experiences of different methods, consultations with health professionals, negotiations with sexual partners and perceptions of different risks such as pregnancy, side effects and sexually transmitted infections. The observations recorded the topics of conversation, questions, requests and responses and the apparent demeanour of the health practitioner and the woman. Background information is only known for the woman subsequently interviewed, unless specifically revealed during the observation.

The transcripts and fieldwork notes were analysed for emerging themes. Initially the analysis was guided by the interview topics, and by comparing specific experiences, such as use of a particular method, or first contraceptive use. As familiarity with the data grew, other themes emerged, which necessitated the constant reassessment of data by both re-reading the transcripts and repeated listening to the interview tapes to ensure that the analysis was valid. For each theme identified, the transcripts were searched both manually and using key-word searches for the sections of interview transcripts or fieldwork notes where the theme arose. Separate documents were then produced for each theme containing all the identified sections of the data to allow systematic comparison and to build links between themes. Within this article, the quotations have been selected as they

seemed to best illustrate the women's feelings, and it is made clear whether this was an individual experience or if it was representative of a broader viewpoint.

Although my sample did not reflect the diversity of class and ethnic backgrounds that I had hoped for, the interviews and observations did provide me with a vast amount of rich material to work with. While the generalizability of the findings may be limited, as Fielding states 'the compensation for this is the depth of understanding gained . . . which can be a rich source of ideas for further work' (1993: 169).

The contraception encounter

With my experiences of doctors . . . It is sort of like they just write a prescription, and that's it . . . what I mean . . . you can't talk about if it is right for you . . . you mainly get information from other women, who have had the coil, who have had the pill, and things like that. (Christine)⁴

Contraception is the most common reason for women to make a doctor's appointment in Britain (Doyal, 1997), yet one of the most striking features of the interviews was although they recognize that the technologies have effects on their health, and they have to access them through medical professionals, the women did not appear to consider that doctors were 'experts' in this area. As the quotation above illustrates, Christine, like most of the other women I interviewed, relies on other women in her social networks for information or validation of her contraceptive choices rather than health professionals.

In this section, I will begin by discussing the women's perceptions of encounters with GPs, and why they see contraception as at the boundaries of medical expertise. I will then consider how the clinic encounter differs both in terms of ideological and material arrangements. In the last section I will show how gender is implicated in both the perceptions of the specific sites and in constructing female staff as experts.

Doctors' authority?

For many of the women, accessing contraception was an unproblematic experience. The women tended to decide what method they wished to use, made an appointment with either their GP surgery or family planning clinic and successfully accessed the method they had chosen. Indeed, what was often clear was that the women did not expect their decisions over contraception to be questioned, with the only possible exception being if there was a medical contraindication that they had not known about. Consequently, when the women did have their decisions denied or questioned by doctors they often felt indignant and that the doctor was exerting illegitimate power. In the following example, Alex describes her reaction to the denial of her contraceptive choice:

I was on Marvalon, and there was a big scare, with this particular brand. I spoke to my doctor . . . er . . . and he said he thought it had been blown out of proportion, and so did I, we were both happy for me to stay on it. Then I had to go back to the doctor's, in a rush, because I had to take the pill the next day . . . ummm . . . my doctor wasn't there, a locum was there, and he insisted on changing my pill. And because I had to take it the following day, I couldn't really argue with him, you see . . . I tried to insist, but he was not having it, not under any circumstances, no . . . and I had to have the pill for the following morning . . . I was stuck . . . I told him that I had discussed it with my regular doctor, and both of us were happy for me to stay on it . . . ummm he wasn't having it . . . I was very angry, very annoyed . . . because I had discussed it with my doctor and we both agreed, yes, I am happy staying on that one, and he insisted . . . he was almost . . . how should I put it . . . 'I know more than you, you are only a patient, take this prescription and go away' . . . That is the impression I got from him . . . I felt belittled . . . [...] the doctor said, you can't have it, it has been withdrawn . . . but I found out, I asked the chemist, he said no they hadn't withdrawn it . . .

As this extract shows, Alex questions not only the locum's actions, but also the basis of his authority. She described him as having an arrogant attitude, not only wrongfully exerting power in refusing her prescription but also trying to mislead her by telling her the drug had been withdrawn when it had not. She clearly did not expect to be treated as 'only a patient' who should 'go away' with a prescription, yet in her eyes that is precisely what happened.

The exasperation felt by women who had their requests for particular methods of contraception declined by GPs is a stark illustration of the contested boundary of medical expertise. In addition to Alex, Christine and Bernadette all described incidents in which requests for particular forms of contraception had been denied by GPs. (All three of these women subsequently became clinic users, although they did not all change directly after their requests were denied.) Yet, these were not the only accounts in which medical expertise over contraception was questioned.

The women clearly distinguished between contraception and medical matters, and this disassociation was an important part of their explanation for their GP's perceived lack of expertise. GPs were understood to have a 'tough job', and to be 'pushed for time', with 'other things on their mind'. Sharon commented:

I think GP surgeries are really rushed. Because they have that much to do, I mean they have got that many people . . . I suppose contraception, it is not really classed as an illness, so they don't really want to go into that too much.

For Sharon, like many of the other women, contraception is different from 'illness'. While they expect GPs to take an interest in, and have knowledge about, medical matters, contraception was considered not really to fit into that category, and thus doctors are perceived to be either unwilling or to have insufficient knowledge to be able to discuss it in more detail.

Sonia and Rebecca both felt that there were definite limits to a doctor's knowledge, and while they might tell you 'what they know', this was unlikely to be the full story. Indeed for Sonia there was a difference between medical reports and 'real life'. Although she felt that the Depo-Provera injection recommended by her doctor was a 'bad choice' as she had experienced so many problems, she felt that her doctor could not have been expected to be aware of all the possible consequences because it was a new method. She felt that reports of medical trials were not sufficient, and that doctors could only be expected to develop an understanding of any problems such as side effects, after they had been told about the patient's experiences of them. This understanding of the role of practice in medical knowledge may be linked to her employment as GP surgery receptionist, yet other respondents employed within health-care settings, including those who had trained as nurses, did not explain medical knowledge in this way.

While for some of the women contraception simply fell outside the range of doctors' expertise, others were far more critical of GPs. Martina felt that GPs deliberately withheld information from women, and it was only patients who knew the right questions to ask who had a chance of getting sufficient information to make an informed choice. She stated that she felt that, in general, doctors 'do tend to treat people as if they are not particularly intelligent', and that you were unlikely to get the 'whole story' about the side effects or health implications from a GP.

Many of the women interviewed moved to a different provider of contraception, following a dispute or an unsatisfactory experience, yet seemed to retain their trust in their GP. Bernadette had made an appointment at the clinic following a refused request for the Mirena coil (Inter Uterine System IUS) at her GP. She stated:

I thought it [the clinic] was wonderful. I am glad I went actually because . . . my own doctor, he had said, who I speak very very highly of, he was very against me. He was against the Mirena coil. And it was him that suggested sterilization . . . I have got great faith in the practice . . . but doctors have their own reasons for recommending certain things . . . some friends have said, it is because it is so expensive, but then surely so is sterilization . . . But I thought it is a bit drastic for the few years I have left . . . The other doctor [clinic] said that it was actually safer, than having sterilization, so that's my next battle [laughs].⁵

Lupton's (1996, 1997) studies have shown that most patients are unlikely to be 'model' consumers who exercise choice over their health professional because of their emotional dependence on doctors when they are ill. But as contraception is not perceived by the women as a 'medical matter', this allows them to change providers without necessarily negating their trust in their doctors. Contraception is simply reclassified as an area beyond the doctor's expertise. Interestingly, in a survey of GPs reported on *Watchdog Healthcheck* (BBC1, 11 June 2001) 25 percent of GPs felt that the contraceptive pill should be made an over-the-counter medicine. With general

support from both the British Medical Association and the Royal Pharmaceutical Society, emergency hormonal contraception has already been switched, which indicates that perhaps many professionals are also reframing contraception as outside the boundaries of medicine. Moreover, perceptions about the limit of GPs' interest and knowledge about contraception were often cited as reasons for registering at the family planning clinic for contraception.

Family planning clinic encounters

The women who had used the clinic described the contraception consultations in very different terms from their experiences in GP surgeries. Most felt that in the clinic they were more likely to be able to obtain expert knowledge about the different methods of contraception. In contrast to an appointment with a GP, the women felt that at the clinic the encounter was 'more comfortable', the clinic had 'specialist knowledge', they could take 'time to discuss things', and it was 'easier to ask questions'. Moreover, several of the women had moved to the clinic specifically because of failed negotiations with their GP. For example, Christine had had her request for Depo-Provera turned down by her GP so she had gone to the clinic to ask there.⁶ She commented:

I think this clinic is so much better, because it is based around women. It is not based around a man coming in with a cold, or a man coming in with a poorly finger. It is based around women's contraception and not getting pregnant, well hopefully not getting pregnant. They can tell you about it ... [...] they were more understanding ... ummm I told them my problems, and ummm, they went through things with me. And like, I asked to go on the pill injection ... [...] I explained to the woman doctor and she was fine ... she accepted the reason, and she was quite happy about it ... and then they gave me Depo-Provera.

In this description of the clinic we can see several of the differences that the women perceived between the clinic and their GP surgery. The clinic is constructed as a place by and for women. It is 'based around women' and their specific need for contraception, and seen not only as a site of specialist knowledge but one where women can take time to 'go through their problems'. This meant that women felt able to make appointments just to discuss the different options, without necessarily making any decisions. On the other hand, GP surgeries were deemed to be not only far too busy for this type of appointment but also, as their prime concern was with 'medical' matters, they were much less likely to be able to discuss the options.

Although not all the women had switched to using the clinic because they had been refused a particular method of contraception, like Christine, almost all the clinic users felt that the clinic staff had a much higher level of expertise. As well as more likely to be 'up to date', they were considered to be able to offer 'a wider range' of contraception. Many of the women changed from their GP to the clinic when they had chosen to use IUDs,

because they felt that the clinic staff would be more skilled in fitting them.⁷ Indeed, it was clear not only from the interviews but also from my observations that many women checked the validity of advice they had obtained from GPs with the staff at the clinic. Karen, for example, stated that:

If ever I have wanted advice about the pill I have gone to the clinic . . . [. . .] because people know what they are talking about, whereas if you go to your GP, and when I ask about the side effects [of other medication], and I ask 'Will it have an effect on the pill?' 'Oh no, no.' And I think I will ring up the women's clinic anyway, because I don't think a lot of them do know half the time.

During my fieldwork period, I observed the staff routinely answering similar telephone queries, as well as talking through other issues. An example concerned a telephone call from a young woman who had picked up her first prescription but was unsure if the doctor had given her the right instructions about how to start taking the pill. Significantly, it was the family planning nurses who gave almost all of this telephone advice.

The other reason given by some of the women for using the clinic rather than their GP was that they did not feel comfortable discussing contraception, and by implication, their sexual lives, with their 'family doctor'. Charlotte spoke of feeling more comfortable at the clinic, where she did not feel as embarrassed, and stated that she had not wanted her appointment to be in the 'family environment' of her GP's surgery. On the occasion when we had met, Charlotte had gone to the clinic to request the emergency hormonal contraception, and it is possible that the construction of the users of the emergency hormonal contraception as 'irresponsible' (Barrett and Harper, 2000) heightened her concerns about using her 'family doctor'.

Paula had also chosen to use the clinic because of the anonymity it afforded. Paula reported that her GP had known her and her family for many years, and that if she had gone to her doctor to ask for a prescription for the pill it would have been very awkward, as the doctor knew that her husband had previously undergone a vasectomy. Paula described how she felt that her doctor would disapprove of her new relationship, and said she did not want to be questioned about her marital break-up. In this case, by accessing the contraceptive pill through the clinic, Paula could avoid what she thought would be an extremely awkward doctor's appointment. She stated that:

My GP knows my family quite well . . . And she always says 'how is the business going, and how are the kids?' and so . . . I suppose it shouldn't bother me really . . . Because it is kind of a professional arrangement . . . but it just does . . . I know that I couldn't ask, because she knows that my husband has had a vasectomy . . . she would know that I have another relationship . . . that I have split my marriage up . . . I just felt too embarrassed to go and see her.

By accessing the different space provided by the clinic, she was exercising agency in an effort to minimize any discomfort and place herself in a different position in relation to the health professional she needed to consult. By

changing the venue of the contraception consultation, she could minimize judgements about her behaviour and would therefore not feel disadvantaged within the encounter.

Gendered spaces and embodied knowledge

Throughout the interviews, there also emerged a gendered sense of place, with the GP surgery appearing to be a masculinized space while the clinic was seen as a feminized space. This pattern did not seem to be affected by the presence of either the male doctors who worked at the clinic; nor the female GPs and practice nurses who dealt with contraception in many surgeries. In general, GP surgeries were considered to be involved in a 'heroic' battle between medicine and disease (Lupton, 1998). They were understood to be disciplined places with spartan communication, where staff did not have the time to indulge women with in-depth discussions about contraception. Although in practice many women did feel able to discuss contraception with their GPs, these doctors were considered to be exceptions rather than representing a different model of doctor/patient relationship.

In contrast, the clinic appeared to be based on a more feminine model. It was a space for discussion, more caring and importantly for the *sharing of experiences*. This is how Sharon describes the atmosphere at the clinic:

I like the Well Woman [clinic], I thought it was the better option . . . [...] they are just nicer to talk to, they just explained everything . . . I just know that they have got the time to sit and talk to you about things as well . . . They understand better because they have to go through the same things themselves. They . . . without mentioning any names, they just explained if anyone had bad experiences or good experiences. It was just nice, because you know you are getting genuine feedback, you know . . .

As this comment illustrates, the clinic expertise that was valued by the women was not just found in the specialization of the clinic, but rather in its embodied knowledge. The women all assumed that the (female) staff would be users of contraception, so the foundation of their expert status was a combination of their specialized training and the embodied knowledge gleaned from their bodily experiences as users of contraception. This may also be why the women felt it was far better to have an IUD fitting at the clinic. Furthermore, it was this expertise based in embodied knowledge that credited the (female) family planning nurses with more authority than (male) GPs. While the male doctors who worked at the clinic were not considered to have the expertise of women health professionals, the different regime of the clinic which allowed for longer appointments, and more discussion meant that the women still felt it to be a feminized space.

However, this expectation of a caring, sharing space meant that when disputes or problems arose at the clinic, the women appeared to be perplexed. For example, I observed one woman having her request for the combined pill being turned down because of her family's medical history.

Throughout the consultation, she tried to insist that her mother's history of heart problems should not affect her being able to take the pill, and at one point she asked the doctor 'What would you use instead?'. In a conversation immediately after the consultation⁸ she commented: 'She [the doctor] should have let me have them. It's not such a big deal, I bet she'd take them herself if she were me . . . how would she like it?' As this observation illustrates, when women consult female health professionals about contraception, they expect embodied advice. The discussion is deemed to be based not just on knowledge gleaned from their medical training but from their personal use of contraception. While the clinic was considered to be a specific expert space, this embodied knowledge could also be found in female practice nurses and GPs. Indeed, many women implied that the delegation of contraception to (female) practice nurses was increasing the level of expertise to be found within GP surgeries. As Joan stated:

Well, I think sometimes they [doctors] might not be able to talk it through . . . in which case . . . I think they should be saying 'I will make you an appointment to see the nurse' . . . because there are a lot of district nurses than ummm . . . can talk frankly about contraception, you know . . . I've had experience of that.

The perception that expertise arises from embodied knowledge is thus a crucial component in the establishment of trust for these women. Contraception is an embodied technology, and it is women's bodily experiences that are perceived to form the basis of 'expert' knowledge. Thus when seeing female health professionals, women made the 'leap of trust' (Möllerling, 2001) based on an assumption that they would have acquired this embodied expertise.

Conclusion

For the women informants, medical consultations for contraception are divided not only in terms of whether the encounter takes place in a GP surgery or a family planning clinic, but a clear distinction is also made between female and male health professionals. While they recognized that contraceptive products often impact on their health and that they have to access them through medical professionals, the women interviewed did not necessarily construct doctors as having expert contraceptive knowledge. Women health professionals are perceived as the ones who 'know' about contraception, through an assumption that they are contraception users. This embodied expertise is valued above their formal medical training. In other words, contraception is constructed as distinct from 'medical matters' and thus when doctors deny women's requests they are considered to be exerting illegitimate power. Moreover, GP surgeries and family planning clinics are constructed as differently gendered spaces, which alters both the expectations and the experience of the contraceptive consultation for the actors involved.

Consequently, contraception consultations further complicate the model of health consumers. The women's accounts often portrayed acquiring contraception as an act of consumption, and the women did choose or change contraceptive service providers to achieve the service they wanted. They also did not expect to have their choice of contraceptive method denied. Yet, while these findings do suggest an ideal type of health consumer, their recognition of the health implications of contraception meant that the women also acknowledged a need for expert opinion, and their choice of health-care provider was often based on their opinion of who and where this expertise was deemed to arise.

This confirms Lupton's (1997) argument that the role of active health consumers and passive patient are not necessarily separate but can be intertwined within the same doctor/patient relationship. However, while Lupton has argued that people often need faith in their doctors due to their vulnerability when sick, these findings illustrate how this complex balance also affects the 'well'. While women may feel disadvantaged in contraception consultations, particularly if they are trying to access a method which goes against the advice of a health professional, the widespread availability of alternatives (such as condoms) does not place them in the same position of emotional dependency. Indeed, contraception consultations within family planning clinics are unlikely to ever be affected by any history and/or future of a doctor/patient relationship involving vulnerability through illness. Wynne (1996) has argued that the public often have ambivalent feelings towards 'experts' and science because they recognize that their limited knowledge always places them in a dependent position. Consequently, rather than illness per se creating the emotional dependence on doctors, perhaps it is the recognition/refusal of their own dependency that plays out in the active consumer/passive patient interplay.

These findings further illustrate the complex relationship between trust and 'expertise'. In the eyes of these women, formal training was not sufficient to accredit male doctors with expert status. It was only when this knowledge was combined with embodied experiences that contraception expertise was deemed to arise. Consequently, regardless of their training or experience, it was only female health professionals who fully gained recognition as 'experts' on contraception. Furthermore, while trust was established through the phenomenological processes of the patient (Lee-Treweek, 2002), it is grounded in the women's ideas about the importance of embodied knowledge. The women interviewed assumed that female health professionals would be, or have been, contraceptive users, and this 'everydayness' is significant in these particular findings.

Mechanic and Meyer (2000) have shown the complexity of trust in doctor/patient relationships, and how it can be related to a variety of factors including type of illness/disease, the patient's socio-economic background as well as the interpersonal relationship between a patient and their doctor. They suggest that the medical profession should not make assumptions

about trust, and that developing skill in trust-building strategies needs to be part of professional training (and organizational context). Yet while this research supports a complex model of trust, it also suggests that there may be limits which skill-training cannot overcome. Moreover, if trust is gendered, this also raises the questions such as whether other embodied factors like class, ethnicity or age may also be important. Mechanic and Meyer (2000) suggest that level of education, for example, affects the sources of information people use and thus the way they judge the technical competence of their doctors. However, as an individual's level of education is often related to socio-economic issues such as class, embodiment may also be an integral factor.

The anomalous position of contraception within medicine as a technology of ongoing prescriptions for the 'well', means that the role of embodiment in establishing trust and expertise may not be generalizable to other doctor/patient relationships. Nevertheless this is an area that warrants further consideration.

Notes

1. Emergency Hormonal Contraception is now available without prescription, and condoms are freely available. All other hormonal or device methods require at least one visit to a surgery or clinic.
2. It has also been suggested that the original design of the contraceptive pill with a 21/7 schedule and thus a withdrawal bleed was for psychological reasons rather than any biological need (Thomas and Ellerston, 2000).
3. Websites offer the most up-to-date information on the side effects and health implications of different methods of contraception. Two good sources are <http://www.fpa.org.uk> (the Family Planning Organization) and <http://www.reproline.jhu.edu> (reproductive health information online at Johns Hopkins University).
4. All names have been changed.
5. At the time of the study, the family planning clinic could not prescribe the IUS for budgetary reasons. Women had to ask their GP for a prescription, and then bring the IUS to the clinic for fitting. Bernadette had not known this prior to her appointment at the clinic.
6. Christine had been fitted with an IUD but this resulted in heavy periods. She reported that when she had asked her GP to change to Depo-Provera, he had instead prescribed something to reduce the bleeding. Christina did not know why her GP had not agreed to her request.
7. Some GP surgeries do not have any doctors trained to fit IUDs, and so routinely refer women to family planning clinics. However, most of the women I interviewed stated that they had the option of being fitted by the GP surgery, but had chosen to be fitted at the clinic.
8. This woman only consented to contact at the clinic, so I was unable to explore this issue in more detail with her.

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